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IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner,*

v.

KENNETH DONALDSON, *Respondent.*

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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INTEREST OF AMICUS CURIAE

The American Psychiatric Association (A.P.A.), founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Over 21,000 of the nation's approximately 25,000 psychiatrists are members of the Association. The A.P.A. has participated as an amicus curiae numerous times in cases throughout the country involving mental health issues.

Amicus believes this case to be of historic importance to the future of mental health care in the nation's public mental institutions. The landmark ruling below that there is a constitutional right to treatment—and the difficult question of how to enforce that right—are of immense concern to members of the A.P.A. and to their patients.

CONSENT OF THE PARTIES

Amicus is filing this Brief with the consent of both parties, whose letters of consent have been filed with the Clerk.

SUMMARY OF ARGUMENT

1. Amicus Curiae American Psychiatric Association, whose members always have worked to implement the right of psychiatric patients to receive adequate care and treatment, wholeheartedly endorses the decision below that the Constitution requires states to provide meaningful treatment when they institutionalize mentally ill citizens. Civil commitment of the mentally ill results in deprivation of the precious right to liberty itself. Thus, due process of law requires that states in fact provide the treatment which they promise when asserting a governmental interest to justify such commitment. When that promise is broken, and "treatment" turns into neglect, the supposedly benevolent purpose of the commitment becomes a cruel hoax, masking the violation of these citizens' fundamental constitutional rights.

2. To enforce this constitutional right to treatment, courts should require states to supply sufficient resources to give each patient a realistic opportunity to receive adequate treatment. Individual doctors employed at these institutions should have a constitutional duty to try in good faith to devote their professional skill to the best possible treatment for each of their patients. When the institutions' resources are inadequate, however, doctors who have tried in good faith to treat their patients should not be personally liable in damages to those patients who received insufficient treatment. To hold the doctor rather than the institution liable in such cases will deter psychiatrists

from working at the institutions where they are most needed—those where the current level of treatment is most inadequate—and will seriously jeopardize enforcement of the patients' right to treatment.

ARGUMENT

I. THE FOURTEENTH AMENDMENT GUARANTEES A RIGHT TO TREATMENT TO PERSONS INVOLUNTARILY COMMITTED TO STATE MENTAL INSTITUTIONS.

When the state confines a citizen in a mental institution involuntarily, the state's action affects some of the most basic rights protected by the Constitution. For what is usually an indefinite period of time,[1] the citizen loses his or her liberty—an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970). Not only do committed citizens lose all freedom of movement, privacy, and association, but most states also strip away their basic civil rights, such as the rights to vote, serve on juries, make a contract, or keep custody of their own children.[2] Moreover, former mental patients are often stigmatized by a society which still too frequently demonstrates an "irrational fear of the mentally ill."[3] Such stigmatization can

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[1] *See Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1193 (1974) (hereinafter, "*Developments*").

[2] *Id.* at 1198-99.

[3] *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 62-63 (1969-1970) (testimony of Dr. Morton Birnbaum). *See generally* Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations*, 70 J. ABNORMAL PSYCHOL. 47 (1965) (people thought to be mentally ill viewed unfavorably although their behavior is normal); Sarbin & Mascuso, *Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness*, 35 J. CONSULT. PSYCHOL. 159, 162 (1970) (public considers the mentally ill dirty, worthless, and dangerous).

itself constitute a deprivation of liberty in the constitutional sense. *See Board of Regents* v. *Roth,* 408 U.S. 564, 573 (1972).

Thus, this Court has recognized that civil commitment of the mentally ill involves a "massive curtailment of liberty." *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972). It affects "fundamental rights," *see Baxstrom* v. *Herold,* 383 U.S. 107, 113 (1966), which are encompassed by the Due Process Clause of the Fourteenth Amendment. *In re Ballay,* 482 F.2d 648, 655 (D.C. Cir. 1973).

It is well established that governmental actions affecting such constitutionally protected interests must bear at least a rational relationship to legitimate state ends. *Williamson* v. *Lee Optical Co.,* 348 U.S. 483, 491 (1955); *Nebbia* v. *New York,* 291 U.S. 502, 525 (1934); *Meyer* v. *Nebraska,* 262 U.S. 390 (1923). The Court has made clear that this principle applies to procedures for the involuntary confinement of the mentally ill or disabled. *Jackson* v. *Indiana,* 406 U.S. 715, 738 (1972):

> At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.

See also McNeil v. *Director,* 407 U.S. 245, 250 (1972) (duration of confinement "must be strictly limited" in accord with state's purpose for commitment); *Humphrey* v. *Cady, supra,* 405 U.S. at 514 (allegation that no psychiatric treatment provided after commitment under Sex Crimes Act presents "substantial constitutional claims").

The court below identified two basic state purposes for civil commitment of the mentally ill—a *"parens patriae"* rationale, *i.e.,* to benefit the person committed; and a "police power" rationale, *i.e.,* to protect society from dangerous individuals. 493 F.2d at 521.[4] Under either rationale, involuntarily committed mental patients[5] have a constitutional right to psychiatric treatment.

A. Parens Patriae Commitments

The *parens patriae* power generally refers to the state's power to serve "as guardian of persons under legal disabilities to act for themselves." *Hawaii* v. *Standard Oil Co.,* 405 U.S. 251, 257 (1972). It has served to justify special restrictions on the rights of

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[4] *See* Note, *Civil Commitment of the Mentally Ill: Theories and Procedures,* 79 HARV. L. REV. 1288, 1289-97 (1966); Note, *The Nascent Right to Treatment,* 53 VA. L. REV. 1134, 1138-39 (1967); Case Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment,* 86 HARV. L. REV. 1282, 1288-91 (1973).

Typically, state statutes recognize three separate criteria for commitment of the mentally ill: need for care or treatment (*parens patriae*), danger to others (police power), and danger to self (predominantly *parens patriae,* but arguably also police power to the extent that the state is acting to prevent the crime of suicide). An American Bar Foundation study in 1971 reported that danger to self or others was the sole criterion for commitment in nine states; need for care or treatment was the sole basis in six other states; 18 additional states include both criteria as alternative bases; and the remaining states enumerate no statutory criteria. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 36-49 (rev. ed. 1971), *cited in Jackson* v. *Indiana,* 406 U.S. 715, 737 n.19 (1972).

[5] While Amicus believes that there generally may be little practical distinction between "voluntarily" and "involuntarily" committed patients, and that all patients should receive adequate psychiatric treatment, the constitutional principles discussed here apply only when the state acts to deprive citizens of liberty against their will. *See generally* Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill,* 66 NW. U.L. REV. 429, 452 (1971).

children, such as compulsory school attendance laws.[6] Application of the doctrine to commitment of the mentally ill dates back at least to an 1845 opinion of the Massachusetts Supreme Judicial Court, which authorized the commitment of a nonviolent individual on the theory that it was "conducive" to restoration of his sanity. *In re Oakes*, 8 Law Rep. 122, 125 (Mass. 1845). Thus, even where an individual poses no danger to society, frequently a state will invoke the *parens patriae* rationale to justify commitment for "treatment which it believes will be in the best interests of the person." *In re Ballay, supra*, 482 F.2d at 658.[7]

[6] *See, e.g., Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944) ("Acting to guard the general interest in youth's well-being the state as *parens patriae* may . . . requir[e] school attendance.").

[7] The *parens patriae* rationale might be thought to imply that the involuntarily committed mental patient not only has a *right* to treatment, but also has a *duty to accept* treatment that the state is providing for the patient's own good. *See generally Developments* 1344-51. Nevertheless, Amicus believes that recognition of the right to treatment is not inconsistent with allowing most patients a right to refuse treatment. In the overwhelming majority of cases, cooperation of the patient is essential to meaningful psychiatric therapy. *See* American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458, 1459 (1967) (comprehensive treatment plan requires patient cooperation). Moreover, forcing treatment on unwilling patients may run afoul of important First Amendment principles. *See Winters* v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) (involuntarily committed Christian Scientist has right to refuse medication treatment). *See generally* Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1974). A rule accommodating these possibly conflicting considerations might allow the state to commit a patient for a limited time, while the physician sought to convince the patient to accept needed treatment. If, however, the patient continued to refuse treatment, and if the patient had not been judicially declared incompetent, long-term *parens patriae* commitment could not be justified, and release would be required. *See* Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. FLA. L. REV. 494, 504-05 (1973); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 112-13 (1967). *See also McNeil* v. *Director*, 407 U.S. 245 (1972).

Arguably, such a temporary deprivation of liberty, when accompanied by adequate treatment for a mental disability, may serve to restore the citizen's meaningful, long-term liberty.

Whatever the limits of the *parens patriae* doctrine,[8] at the very least, when a state involuntarily confines one of its mentally ill citizens to an institution on the ground that it is acting in a humanitarian way pursuant to its *parens patriae* power to aid that individual, due process requires that the individual in fact be given such aid and treatment as would be reasonably calculated to benefit or cure the citizen. Since the state's asserted purpose for a *parens patriae* commitment[9] is to provide treatment,[10] "due process requires

[8] *See In re Gault*, 387 U.S. 1, 13 (1967) (meaning of *parens patriae* rationale is "murky"); *Kent* v. *United States*, 383 U.S. 541, 555 (1966) (*parens patriae* philosophy of the juvenile court "is not an invitation to procedural arbitrariness"). Indeed, some commentators argue that *parens patriae* commitments should be limited to cases where the court makes a finding of *incapacity*, rather than simply mental illness. *See, e.g.*, Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, 4 TRIAL 29, 32 (Feb.-Mar. 1968); Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1, 33-37 (1971); Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822, 830 (1967).

[9] In many commitments, of course, the state asserts *both* a *parens patriae* and police power purpose. *See* p. 11, *infra*.

[10] In cases of mentally ill individuals who are totally unable to care for themselves, or who may be dangerous to themselves, a state might assert a *parens patriae* interest simply in providing safe, custodial care, even if the individual's illness might not be curable. This justification is inapplicable to the instant case, of

that the nature and duration of commitment bear some reasonable relation to" that purpose. *Jackson* v. *Indiana, supra,* 406 U.S. at 738.

As the court noted in *Wyatt* v. *Stickney,* 325 F. Supp. 781, 785 (M.D. Ala.), *enforced,* 334 F. Supp. 1341 (M.D. Ala. 1971), *and* 344 F. Supp. 373, 387 (M.D. Ala. 1972), *aff'd in part and remanded in part sub nom. Wyatt* v. *Aderholt,* No. 72-2634 (5th Cir., Nov. 8, 1974):

> To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process.

Accord, Welsch v. *Likins,* 373 F. Supp. 487 (D. Minn. 1974). *See also Rouse* v. *Cameron,* 373 F.2d 451 (D.C. Cir. 1966) (dictum).

This Court, too, has emphasized that a curtailment of liberty can only be justified where the "theoretical purpose" embodied in the *parens patriae* rationale is matched by "actual performance":

> While there can be no doubt of the original laudable purpose of juvenile courts, studies and critiques in recent years raise serious questions as to whether actual performance measures well enough against theoretical purpose to make tolerable the immunity . . . from the reach of constitutional guaranties. . . . There is much evidence that some juvenile courts . . . lack the personnel, facilities and techniques to perform adequately as representatives of the State in a *parens patriae* capacity. [*Kent* v. *United States,* 383 U.S. 541, 555-56 (1966).]

Accord, e.g., Nason v. *Superintendent,* 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968) ("remedial aspect of confinement [must] have foundation in fact").

When treatment is not provided, a hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense." *Ragsdale* v. *Overholser,* 281 F.2d 943, 950 (D.C. Cir. 1960). Such confinement bears no relation to the state's asserted purpose for a *parens patriae* commitment. In *Commonwealth* v. *Page,* 339 Mass. 313, 159 N.E.2d 82 (1959), the petitioner was civilly committed to a treatment center for sexual offenders on the day before his criminal sentence was to end. However, because the treatment center was not fully constructed, he was returned to the prison where he received only the same group and individual therapy as the general prison population. The court released the petitioner on habeas corpus, holding (339 Mass. at 317-18, 159 N.E.2d at 85) (emphasis added):

> [T]o be sustained as a nonpenal statute, in its application to the defendant, it is necessary that the remedial aspect of confinement thereunder have foundation in fact. It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal. While we are not now called upon to state the standards

course, since it was not the basis of Mr. Donaldson's commitment. *See* 493 F.2d at 517, 521. Moreover, in such instances due process would require, at the very least, that a) at the commitment hearing the state assert *and prove* this narrower rationale for confinement, without reliance on any alleged treatment benefits to justify the commitment; and b) that the duration of the commitment be strictly limited to the period during which the patient is unable to care for himself or herself. *See Developments* 1221-22. *But see Wyatt* v. *Aderholt,* No. 72-2634, slip op. at 712 (5th Cir., Nov. 8, 1974) (while "need for care" may be rational state interest, mere care, without treatment, does not outweigh massive curtailment of liberty involved in involuntary commitment).

which such a center must observe to fulfill its remedial purpose, we hold that a *confinement in a prison which is undifferentiated from the incarceration of convicted criminals is not remedial so as to escape constitutional requirements of due process.*

In the instant case, the lower courts have found that Mr. Donaldson was not a dangerous individual, and that his commitment was justified by the state solely on the *parens patriae* rationale that he was in need of treatment. 493 F.2d at 517, 521. Under such circumstances, the state's continued long-term confinement of Donaldson, without providing the medical treatment alleged to be the basis of that confinement, was arbitrary state action, depriving Donaldson of his liberty without due process of law.

B. Police Power Commitments

The state's police power has also been suggested as a rationale for commitment of mentally ill individuals who are found to be dangerous to society. Amicus believes that in fact very few of the mentally ill present such a danger.[11] In addition, the psychiatric community cannot assure this Court that there are any highly

[11] At least ninety percent of patients in American mental hospitals are considered harmless to others. *See* American Psychiatric Association, *supra* note 7, at 1459. *See also* H. Brill & B. Malzberg, Mental Hospital Service (APA) (Supp. No. 153, 1962) (sample crime rate before commitment and after release a fraction of that of the general population); J. Rappeport, The Clinical Evaluation of the Dangerousness of the Mentally Ill (1967); Giovanni & Gureal, *Socially Disruptive Behavior of Ex-Mental Patients,* 17 Arch. Gen. Psychiat. 146, 153 (1967); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations on the Prediction of Infrequent Events,* 18 J. Consult. Psychol. 397 (1954).

reliable techniques for identifying with certainty which of the mentally ill fall into this minority category of dangerous individuals.[12] Amicus recognizes that the truly dangerous mentally ill pose special problems for society, not only for the legal system, but also for mental health care personnel in that these individuals often are the most resistant to treatment.[13] Nevertheless, whenever the state acts under its police power to deprive a mentally ill person of liberty on the basis of a *prediction* of dangerousness, rather than a finding that the person has committed a criminal act, Amicus believes that the state should provide that person with psychiatric treatment for his mental illness.

It should be emphasized at the outset that a state can not avoid the constitutional requirement of a rational relation to its *parens patriae* purpose of commitment, discussed in Part A, *supra,* merely by verbalizing the additional purpose of protection of society. Any time the state relies at all on a *parens patriae* rationale for confinement, the concomitant constitutional right to treatment discussed above attaches to the person who is the object of such confinement. Where the precise basis in a particular case cannot be determined, the presumption should be that the state was acting at least in part for the benefit of the mentally ill patient pursuant to its *parens patriae* powers.

[12] Studies on "dangerous" mental patients released following *Baxstrom* v. *Herold,* 383 U.S. 107 (1966), indicate that very few of the patients who were released, and who psychiatrists predicted would commit violent crimes, did in fact commit those crimes. *See, e.g.,* Morris, *The Confusion of Confinement Syndrome,* 17 Buff. L. Rev. 651 (1968); for studies on similar groups, *see, e.g.,* J. Rappeport, *supra* note 11.

[13] American Psychiatric Association, Clinical Aspects of the Violent Individual (Task Force Rep. No. 8, 1974).

However, even if the state could establish that benefit to the patient *(parens patriae)* formed no part of its rationale for interference with liberty, but rather that its sole purpose (to which the nature of its confinement need be constitutionally related) was protection of society, there are still severe constitutional problems in involuntary commitment absent an attendant *bona fide* effort to provide adequate treatment. Indeed, such an argument by the state amounts to the assertion that *preventive detention* of the mentally ill for an indeterminate term without treatment is constitutionally permissible.

In addition to holding that a constitutional right to treatment exists for mental patients committed by the state pursuant to a *parens patriae* rationale, the court below alternatively held that due process requires the state to provide treatment as a *quid pro quo* to the civilly committed mental patient, regardless of whether the commitment was under a *parens patriae* or police power rationale. 493 F.2d at 521-525. This statement of the constitutional right to treatment, which also derives from the Due Process Clause of the Fourteenth Amendment, begins with the recognition that long-term detention under our system of justice is generally predicated upon (1) a finding in an adversary proceeding with the full panoply of constitutional limitations and rights, (2) that an individual has committed a specific act defined as an offense against the state, (3) for which a maximum period of detention is explicitly prescribed. *Id.* at 522, *citing Powell* v. *Texas*, 392 U.S. 514, 533, 542-43 (1968). The court below reasoned that whenever the state seeks long-term detention outside of these "three central limitations on the government's power to detain," due process requires that the government provide to the

detained individual some *quid pro quo*—such as beneficial treatment—to justify confinement.

It should be noted that this requirement of a *quid pro quo* as expressed by the court below is deemed to derive from the *substantive nature* of civil commitment as a form of preventive detention, and not merely from the fact that such detention lacks certain procedural safeguards. *See* 493 F.2d at 522 n.21. The right as formulated by the Court of Appeals would appear to be unaffected by, for example, a state procedure whereby indefinite commitment was permitted upon a finding in an adversary proceeding, with full Bill of Rights safeguards, that an individual was "dangerous to others." For even in such a context, the state would still be acting outside two of the above-enumerated "three central limitations on the government's power to detain." Thus, even where the justification for detention is dangerousness to society, if the government wishes to bypass awaiting the effectuation of a specific criminal offense and the adjudication of guilt, with full Bill of Rights protection for the accused, it must offer in return a *quid pro quo*, and rehabilitative treatment is the most commonly recognized form of such an exchange.[14]

Although there is no direct judicial antecedent for this particular formulation of the limitations on the state's right of confinement, close judicial analogy can be found. For example, statutes which attempt to bypass the third requirement—detention limited to a fixed term—have been closely scrutinized by the judiciary

[14] Or, as the Fifth Circuit later restated its *Donaldson* holding, treatment must be provided as the *quid pro quo* society owes for the extra safety it derives from the denial of individuals' liberty. *Wyatt* v. *Aderholt*, *supra*, slip op. at 726.

for some form of therapeutic or humanitarian benefit. In examining indeterminate commitment under the Maryland Defective Delinquent Statute, the Fourth Circuit noted:

> For those in the category . . . it [the statute] would substitute psychiatric treatment for punishment in the conventional sense and would free them from confinement, not when they have "paid their debt to society", but when they have been sufficiently cured to make it reasonably safe to release them. With this humanitarian and progressive approach to the problem, no person who has deplored the inadequacies of conventional penological practices can complain. . . . [However,] deficiencies in staff, facilities and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application. [*Sas* v. *Maryland*, 334 F.2d 506, 517 (4th Cir. 1964).]

See also Miller v. *Overholser*, 206 F.2d 415, 419 (D.C. Cir. 1953) (indefinite commitment under sexual psychopath law justifiable only upon theory of therapeutic treatment); *cf. Robinson* v. *California*, 370 U.S. 660, 666 (1962) (status as drug addict does not meet criterion of commission of specific offense, justifying long-term detention; but "compulsory treatment" might be such a justification); *Ricks* v. *District of Columbia*, 414 F.2d 1097, 1110 (D.C. Cir. 1968) ("Statistical likelihood that a particular societal segment will engage in criminality is not . . . [a] substitute for proof of individual guilt"); *Williamson* v. *United States*, 184 F.2d 280, 282 (2d Cir. 1950) (Jackson, Circuit Justice) ("Imprisonment to protect society from predicted but unconsummated offenses is so unprecedented in this country and so fraught with danger of

excesses and injustice that I am loath to resort to it . . . .").[15]

Even under emergency war-time conditions, this Court has held that exclusion from the area in which one's home is located and constant confinement between the hours of 8:00 p.m. and 6:00 a.m. can be constitutionally justified by "[n]othing short of apprehension by the proper military authorities of the gravest imminent danger to the public safety." *Korematsu* v. *United States*, 323 U.S. 214, 218 (1944) (upholding temporary detention of citizens of Japanese ancestry justified as necessary to prevent espionage and sabotage).

When the state acts under its police powers to detain individuals *full-time* in state institutions for *indefinite periods* of time, "then treatment ha[s] to be provided as the *quid pro quo* society ha[s] to pay as the price of the extra safety it derive[s] from the denial of individuals' liberty." *Wyatt* v. *Aderholt*, *supra*, slip op. at 726. *Compare In re Gault*, 387 U.S. 1, 22-23 n.30 (1967):

> While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures

[15] Enactment of the preventive detention aspects of the D.C. Bail Reform Act, 23 D.C. Code §§ 1322-23 (Supp. I, 1974), has caused much scholarly debate. Although, as in civil commitment, detention of arrestees under the statute is based on predictions of dangerousness, an adversary hearing is provided and detention is strictly limited to 60 calendar days. *See, e.g.*, Note, *Preventive Detention: An Empirical Analysis*, 6 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 291 (1971); Dershowitz, *Imprisonment by Judicial Hunch*, 57 A.B.A.J. 560 (1971); Tribe, *An Ounce of Detention: Preventive Justice in the World of John Mitchell*, 56 VA. L. REV. 371 (1970); cf. Mitchell, *Bail Reform and the Constitutionality of Pre-Trial Detention*, 55 VA. L. REV. 1223 (1969).

> for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a *quid pro quo*.

Thus, Amicus urges this Court to recognize a constitutional right to treatment as the *quid pro quo* society offers for the massive curtailment of liberty extracted in involuntary civil commitment.

Finally, it should be noted that in addition to the *quid pro quo* approach of the court below, there are other difficult constitutional questions concerning involuntary commitment without treatment. First, would not the confining of the mentally ill because of their "dangerous propensities" violate the Equal Protection Clause, in that others with the same propensities are not subject to involuntary confinement? If the interest which justifies making only the mentally ill liable to confinement is the need to protect society, then the classification is both overinclusive, in that most mentally ill are not dangerous,[16] and underinclusive, in that many non-mentally ill are potentially dangerous. Case Comment, *supra* note 4, at 1294. Furthermore, the legislature in singling out a specific subgroup for invidious treatment must show at the very least a rational basis for such discrimination. The only rationale for sequestering dangerous mentally ill individuals, while not seeking confinement of dangerous individuals who are not mentally ill, is the belief that the dangerous propensities of the mentally ill can be the subject of treatment and/or preventive cure.[17] This rationale,

[16] *See* note 11, *supra*.

[17] An alternative argument—that mental illness is a particularly good predictor of dangerousness—simply does not square with the facts. *See* note 11, *supra*. *See also* Morris, *supra* note 12.

of course, fails if adequate treatment is not in fact provided, as there is no "rational relation" between the nature of the confinement and the classification on which it is based. *Cf. Jackson* v. *Indiana, supra,* 406 U.S. at 738. Indeed, since civil commitment affects fundamental interests which are accorded explicit constitutional protection, such as physical freedom, privacy, association, and sometimes the right to vote, the state's classifications in this area should be subject to stricter judicial scrutiny than the requirement of merely a "rational" relationship to the state's interest. *Developments* 1215 & n.83; *see, e.g., Weber* v. *Aetna Casualty & Surety Co.,* 406 U.S. 164 (1972); *Dunn* v. *Blumstein,* 405 U.S. 330, 335 (1972).

Second, if the *quid pro quo* right to treatment discussed above is not sustained, this Court will have to decide whether confining the mentally ill under the police power for their dangerous propensities, without providing adequate treatment, constitutes cruel and unusual punishment under the Eighth Amendment. In rejecting the power of a state to make drug addiction an offense, this Court has noted:

> A law which made a criminal offense of such a disease [as mental illness, leprosy, or venereal disease] would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See *Francis* v. *Resweber,* 329 U.S. 459 [1947] [*Robinson* v. *California, supra,* 370 U.S. at 666.]

In the instant case Respondent might as well have been convicted of a "criminal offense." He was confined in a ward in which one third of the population were criminals. He slept in the same room with the criminal

patients, ate the same food, and was subject to the same regimen. Where no medical treatment is given to the committed mental "patients," the Court may find such a similarity between a nontreating "hospital" and a jail as to warrant the conclusion that involuntary commitment absent treatment is virtually punishment for an illness. Essentially "nothing [has been] accomplished beyond the hanging of a new sign—reading 'hospital'—over one wing of the jailhouse." *Powell* v. *Texas, supra,* 392 U.S. at 529.

C. Elements of the Right to Treatment

In its argument against the recognition of a constitutional right of involuntarily committed mental patients to receive treatment, Petitioner places heavy emphasis (Brief for the Petitioner, pp. 29-45) on the assertion that courts and juries are incapable of making the assessments necessary for the enforcement of this right. Amicus believes that sufficient, well-recognized professional standards do exist so that courts can review the adequacy of treatment without becoming hopelessly immersed in analysis of day-to-day medical judgments. Moreover, as noted by the court below, the fact that the limits of a right may be difficult to draw in particular cases is no reason for denying that the right exists at all, nor is it a reason for denying enforcement of that right in a clear-cut case of violation.

The jury below was instructed that "a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive *such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.*" Instruction 37 (emphasis added). Expert testimony from psychiatrists and psychologists was presented at trial by both

the plaintiff and the defendants on the issue of whether such treatment was in fact provided.

Amicus believes that adequate treatment in the constitutional sense should be defined along the lines outlined by the District Court in *Wyatt* v. *Stickney, supra.* The *Wyatt* court held that there are:

> three fundamental conditions for adequate and effective treatment programs in public mental institutions. These three fundamental conditions are: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. [*Id.,* 334 F. Supp. at 1343.]

Following the legal ruling that these quoted standards are constitutionally required, practical experience has shown that the parties, with the aid of professional groups as amici, can agree on minimum standards as applied to a particular case. *See* detailed minimum standards set forth in *Wyatt* v. *Stickney, supra,* 344 F. Supp. at 383. *See also Wyatt* v. *Aderholt, supra,* slip op. at 716:

> Neither in the district court nor on appeal to this Court have the defendants challenged the detailed set of standards articulated by the district court. They have conceded that if there is a constitutional right to treatment enforceable by a suit for injunctive relief in federal court, those standards accurately reflect what would be required to ensure the provision of adequate treatment.

Amicus feels that there are appropriate and workable legal standards by which the constitutional right to treatment can be judicially defined, implemented and enforced. In a recent report of the American Psy-

chiatric Association's Task Force on the Right to Care and Treatment, the Task Force offered the following definition of treatment (and care, which it distinguished from treatment):

> Adequate care and adequate treatment will be defined separately. Indices of adequate care can be objectively stated with reasonable ease and precision—but the problem of developing criteria for adequate treatment is considerably more complex and more controversial. Adequate care includes the availability of medical care, nutritious and palatable food in sufficient quantity, humane shelter in an uncrowded and pleasant setting, and protection from self and others. These aspects of care should be incorporated *in a total environment which is compatible with basic human comfort and dignity.* Further, the caring environment should be only as restrictive of personal liberty as is necessary to protect and meet the needs of the patient and society. Minimal objective standards have and can be established to define these indices of care. The American Psychiatric Association has periodically developed and reviewed such standards, and has participated in the development of those which are currently in use by the Joint Commission on the Accreditation of Hospitals.[18]
>
> Assurance that adequate treatment is available in a particular hospital or other setting is best achieved by assuring the availability of *a professional staff which is adequate in numbers and training.* Treatment is defined to include active intervention of a psychological, biological, physical, chemical, educational, moral or social nature, where there is some reason to expect that the application of *an individual treatment plan is felt to have a reasonable expectation of improving the patient's condition.* [AMERICAN PSYCHIATRIC ASSOCIATION, POSITION PAPER ON THE RIGHT TO ADEQUATE CARE AND TREATMENT FOR THE MENTALLY ILL AND MENTALLY RETARDED (4th Draft, Oct. 19, 1974) (emphasis added).]

[18] Indeed, the Joint Commission has appointed an Accreditation Council for Psychiatric Facilities to accomplish these purposes.

It can be seen that the APA Task Force definition comports fully with the tripartite judicial standard in *Wyatt* v. *Stickney, supra,* and also with the jury instruction given in the case at hand. Moreover, sufficiently detailed criteria exist for courts to use in applying this broad definition to specific cases. *See, e.g.,* AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES (rev. ed. 1974). While Amicus agrees with Petitioner that there are many different approaches to psychiatry, Amicus disagrees that these differences within the profession preclude a judicial review of the presence or absence of the objectively stated criteria here proposed.

The first standard stated above in the definition of the constitutional right to treatment—a humane psychological and physical environment—is certainly the *sine quo non* of any therapeutic procedures. Such an environment must satisfy the physiological as well as the psychological needs of the patients if care and treatment are to be administered adequately. The APA's *Standards for Psychiatric Facilities* speaks specifically to such objective requirements as space, heating, ventilation, privacy in toilet and bathing areas, day rooms and recreation areas, and conference rooms. *Id.* at 64-66. There is a recognition in the psychiatric community that such facilities must "be designed to promote comfort and dignity and to ensure privacy consistent with the patients' welfare." *Id.* at 65.

Certainly, the court below was correct in holding that when a patient receives "only the kind of subsistence level custodial care he would have received in a prison," 493 F.2d at 512, the standard for adequate treatment of civilly committed patients has not been met.

As to the second factor to be taken into consideration in the judicial evaluation of adequacy of treatment—qualified staff in numbers adequate to administer treatment—there clearly are standards in this area on which agreement of experts can be obtained. For example, in 1958 the American Psychiatric Association promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 61 (rev. ed. 1958). These minimal standards have served as guideposts for the courts in right-to-treatment litigation. *See Rouse v. Cameron, supra,* 373 F.2d at 457-58 & n.33. *See also Wyatt v. Stickney, supra,* 344 F. Supp. at 383.

The final area in which it is urged the courts should set the parameters of the constitutional adequacy of treatment—an individual treatment plan—deals with what is more properly called "treatment" as opposed to "care." The two former indices look toward institution-wide criteria, the third toward the institutionalized individual. There must be a recognized plan of treatment which takes into account the situation, needs and prognosis of the individual patient. At this point it is of course necessary for discretion to play a role. Nor is such a division alien to other areas of forensic medicine. Traditionally in torts, for example, the legal adequacy of treatment is judged in

accordance with standards set by a responsible segment of the medical community:

> Where there are different schools of medical thought, it is held that the dispute cannot be settled by the law, and the doctor is entitled to be judged according to the tenets of the school he professes to follow. . . . A "school" must be a recognized one with definite principles . . . . [W. PROSSER, HANDBOOK OF THE LAW OF TORTS 166 (3d ed. 1964).]

Indeed, a similar standard has already been formulated in the context of fleshing out the meaning of a statutory right to treatment in *Rouse* v. *Cameron, supra.* The *Rouse* Court held that the legal standard of adequate treatment did not require the state to show its treatment would in fact cure or improve the patient, but only that there was a bona fide effort;[19] and further that proof that there is *better* treatment does not necessarily make inadequate the one provided.

With these standards the constitutional right to treatment can be judicially supervised without undue interference into doctors' decisions concerning proper diagnosis and therapy in each case. As the court stated in *Tribby v. Cameron,* 379 F.2d 104, 105 (D.C. Cir. 1967) (emphasis added):

> The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that *it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.*

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[19] Jury Instruction No. 37 given in this case defined adequate treatment as that which would give the patient "a realistic opportunity" to be cured or to improve his mental condition.

Thus, recognition of a constitutional right to treatment should not require "sweeping judicial surveillance over the choice of therapy. . . . Judicial consideration, therefore, would be largely limited to determining whether the choice of therapy was a conscious medical decision rather than neglect; obviously judges have no competence to evaluate the *quality* of a given choice of treatment." *Dobson v. Cameron,* 383 F.2d 519, 523-24 n.2 (D.C. Cir. 1967) (Berger, J., concurring).

While courts cannot and should not employ their resources to arbitrate between conflicting professional approaches concerning the most desirable treatment plan for a particular patient, there are sufficient professional standards recognized within the psychiatric community so that the courts can ensure that a reasonable form of treatment is provided to each individual psychiatric patient.

II. PSYCHIATRISTS EMPLOYED AT STATE INSTITUTIONS SHOULD BE IMMUNE FROM PERSONAL LIABILITY FOR DAMAGES WHEN THEY HAVE MADE A GOOD FAITH EFFORT TO COMPLY WITH CONSTITUTIONAL REQUIREMENTS FOR TREATMENT.

The courts below found the individual doctors employed by Chattahoochee personally liable for the monetary damages resulting from inadequate treatment provided at that institution. In so holding, the lower courts gave exceedingly short shrift to the arguments that the doctors were acting in good faith, that they were attempting to comply with the law as they reasonably understood it, and that the real cause of Mr. Donaldson's injury was the inadequacy of the institutional resources available for his treatment. To ignore such arguments not only results in extreme injustice to individual doctors, who must pay large sums of money for conditions over which they have no

control, but also endangers enforcement of the essential right to treatment that the courts below were seeking to advance.

The briefs of the parties will deal in detail with the question of whether the evidence in the record was sufficient to establish the doctors' good faith. Thus, Amicus will not repeat or review those arguments here. Instead, Amicus wishes to explore what it believes should be the proper standards for a showing of good faith in cases of this kind, and to emphasize the importance of such standards to the future of mental health care in this country.

In determining whether an individual psychiatrist has made a good faith effort to provide adequate treatment for his or her patients, it is essential that the courts focus clearly on the institutional setting in which that doctor is working. When treating an automobile accident victim, a surgeon working under emergency roadside conditions is not expected to meet the same standard of care as if he or she had available the advantages of a modern hospital's intensive care unit and team of supporting specialists. The range of resources available to psychiatrists in different institutional settings is just as great. Therefore, the treatment that psychiatrists provide must be viewed in this institutional context in order to judge fairly whether they have made a good faith effort to treat their patients.

A recent study revealed that the nationwide average patient-psychiatrist ratio in state-run mental hospitals is approximately 70-1.[20] County mental hos-

[20] *See* NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972, at 53 (DHEW Pub. No. (ADM) 74-28, 1974).

pitals, however, still average 500 patients per psychiatrist.[21] The range of patient-psychiatrist ratios throughout the nation is so great that the average psychiatrist in a public mental hospital in Alabama, for example, is responsible for *143 times more patients* than a doctor employed by such a hospital in Colorado.[22]

During Mr. Donaldson's fourteen-year confinement at Chattahoochee, the ratio of patients per staff psychiatrist averaged approximately 800-1. *See* Record at 467. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47% of his or her time to direct patient care.[23] Thus, if each doctor spent an equal amount of time with each patient, as little as one or two minutes per week would have been available for psychiatric "treatment" of each patient at Chattahoochee. Meaningful psychiatric care was not, and cannot be, provided under such circumstances.

The American Psychiatric Association has promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care.[24] These are truly minimum standards, since they "represent a compromise between what was thought to be adequate and

[21] *Id.*

[22] *Compare* NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, 1973, at Table 1 (Aug., 1974) (Alabama), *with id.* at Table 1 (Colorado).

[23] JOINT INFORMATION SERVICE, AMERICAN PSYCHIATRIC ASS'N & NAT'L ASS'N FOR MENTAL HEALTH, ELEVEN INDICES 14 (1971).

[24] AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 61 (rev. ed. 1958).

what it was thought had some possibility of being realized." Solomon, *The American Psychiatric Association in Relation to American Psychiatry,* 115 AM. J. PSYCHIAT. 1, 7 (1958). Yet even these minimal standards, which have been accepted as guideposts by the courts,[25] demonstrate that Chattahoochee needed a vastly larger number of doctors than it actually had in order to provide adequate treatment to its resident population. The A.P.A. standards allow no more than thirty acutely ill patients, or 150 chronically ill patients, per full-time psychiatrist. Thus, while each psychiatrist at Chattahoochee averaged 800 patients, of whom approximately 350 were acutely ill,[26] minimum staffing standards demanded *fifteen* full-time psychiatrists in order to provide adequate treatment to those same patients.

The Court of Appeals analysis of the doctors' liability completely ignores this evidence of the hopelessly inadequate staffing and resources at Chattahoochee. Amicus submits that a legal standard of good faith which allows a jury to find doctors personally liable without consideration of such evidence[27] is really no standard at all.

[25] *See Rouse* v. *Cameron, supra,* 373 F.2d at 457–58 & n.33. *See also Wyatt* v. *Stickney, supra,* 344 F. Supp. at 383.

[26] *See* Brief for the Petitioner, at 7.

[27] As will be discussed in more detail below, the trial court should have instructed the jury to take into account any evidence of limited staff and resources available at Chattahoochee when the jury considered Dr. O'Connor's defense that he made a good faith effort to comply with his legal duty, as he understood it. The lower courts also should have reviewed the propriety of the jury verdict in light of this standard.

It is not clear whether Petitioner properly raised this issue before the trial court. The parties' briefs undoubtedly will discuss

This Court has emphasized repeatedly that state officials should not be liable personally for damages when they have acted in good faith in the performance of their duties. In *Pierson v. Ray,* 386 U.S. 547 (1967), the Court held that plaintiffs could not recover damages from individual police officers for an unconstitutional arrest "if the jury found that the officers reasonably believed in good faith that the arrest was constitutional." *Id.* at 557. The Court last Term in *Scheuer v. Rhodes,* 416 U.S. 232 (1974), made clear that this "qualified immunity" not only extends to more senior state officials, but in fact should be broader as the defendant's "scope of discretion and responsibilities" is broader. *Id.* at 247. *See also Doe v. McMillan,* 412 U.S. 306, 320 (1973).

The official immunity doctrine "seeks to reconcile two important considerations—

> '[O]n the one hand, the protection of the individual citizen against pecuniary damage caused by oppressive or malicious action on the part of [government officials]; and on the other, the protection of the public interest by shielding responsible governmental officers against the harassment and inevitable hazards of vindictive or ill-founded damage suits brought on account of action taken in the exercise of their official responsibilities.'" [*Doe v. McMillan, supra,* 412 U.S. at 319, *quoting Barr v. Matteo,* 360 U.S. 564, 565 (1959).]

that point, and the related question whether the lower courts' failure to consider this issue amounted to "plain error," reviewable in the absence of any objection by the parties. *See, e.g., Silber v. United States,* 370 U.S. 717, 718 (1962); *United States v. Atkinson,* 297 U.S. 157, 160 (1936). Whatever the Court's resolution of these questions, Amicus believes that it is essential that the Court's opinion here emphasize the proper contours of the good faith defense for the guidance of potential litigants and the lower courts.

One court has summarized the doctrine as allowing "a qualified immunity based on good faith performance of duty as the officials understood it." *Roberts v. Williams,* 456 F.2d 819, 831 (5th Cir.), *cert. denied,* 404 U.S. 866 (1971); *accord, e.g., Gaffney v. Silk,* 488 F.2d 1248, 1250 (1st Cir. 1973). Thus, the defense consists of two basic elements. First, courts must focus on the official's understanding of his or her duty; the courts will consider the defense in light of that understanding, so long as it is reasonable, even if incorrect. The second element [28] of the defense provides immunity when the official made a good faith effort to meet that duty, as so understood, even if the effort was unsuccessful.

Regarding the first part of the defense, the law is well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even if those principles later were overturned. As this Court held in *Pierson v. Ray, supra,* 386 U.S. at 557, state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry v. Fisher,* 309 F. Supp. 12, 17 (D. Me. 1970).

[28] In a case where the definition of defendant's legal duty is clear, only the latter element of the defense is relevant. In the instant case, however, where the constitutional contours of the duty are still developing, the two elements are interrelated. Thus, defendant's good faith effort must be measured against whatever legal duty he reasonably should have known was applicable. The question of whether an objective or subjective standard is appropriate in assessing whether a defendant made such a "good faith effort" is now pending before the Court in *Wood* v. *Strickland, cert. granted,* 94 S. Ct. 1932 (No. 73-1285, Apr. 15, 1974).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-20 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous v. La Burt,* 14 App. Div. 2d 560, 218 N.Y.S.2d 738 (1961), *appeal dismissed and cert. denied,* 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson v. O'Connor,* 234 So. 2d 114 (Fla. 1969), *cert. denied,* 400 U.S. 869 (1970). *See also Donaldson v. O'Connor,* 390 U.S. 971 (1968); *Donaldson v. Florida,* 371 U.S. 806 (1962); *In re Donaldson,* 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there should be a constitutional right to treatment. *Wyatt v. Stickney, supra,* 325 F.Supp. 781.

Not only is the constitutional right to treatment a very recent development, but the past decade has also seen major changes in the professional approach toward psychiatric treatment of the seriously mentally ill. Beginning in the 1960's psychiatrists began to recognize that long-term custodial care of the mentally ill, in large and dehumanizing institutions situated in isolated settings, was often counterproductive and therefore should be resisted. Many patients—even those with the most serious mental illness (such as that diagnosed in Mr. Donaldson's case)—could be rapidly returned to home and community. This approach was made possible in part by the advent of effective medications which moderated the symptoms and allowed patients to be managed in the community.

With or without such medications the fundamental approach to most of these patients has now been modified, and every attempt is made to return them to home, family, work, and community as soon as possible. This strategy, the "community mental health approach," has revolutionized the treatment of the mentally ill. That revolution, however, is incompletely realized; many communities lack the facilities, personnel, and outreach programs which make it possible.

Mr. Donaldson was originally hospitalized at a time when the community mental health approach had not been clearly formulated or generally accepted. Much of the testimony given in his case assumes the general acceptance of the community mental health approach without recognizing the changes which were occurring in psychiatry during that period. Thus, not only was Dr. O'Connor judged by a new legal standard, but also his approach to treatment was measured in terms of a new psychiatric perspective.

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson v. Ray* to apply the right-to-treatment principle retroactively by holding psychiatrists personally liable for damages dating back many years before they could have known of this new constitutional duty.[29] Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal

[29] The courts below did not address this retroactivity issue. *See* note 27, *supra.*

doctrine." *Eslinger v. Thomas,* 476 F.2d 225, 229 (4th Cir. 1973). In *Eslinger,* plaintiff challenged the policy of the clerk of the South Carolina State Senate that women were ineligible to serve as senate pages. The Fourth Circuit held that injunctive relief was proper, since the discriminatory policy ran afoul of current constitutional requirements of equal protection. The court went on, however, to reverse the lower court's ruling that the clerk should be liable for damages. The court noted that the defendant's actions had taken place at a time when the law generally tolerated sex-based classifications. *Id.* at 230 & n.5. "Although the clerk may have acted with little sensitivity . . . he acted in the light of a long-standing, albeit vaguely defined, 'custom' . . . . He did no more, or less, than what had always been done." *Id.* at 229. The Fourth Circuit concluded that the defendant should not be liable for failing to foresee a new constitutional principle. *Id.*; *accord, e.g., Haines v. Kerner,* 492 F.2d 937, 941 (7th Cir. 1974) (conduct of officials "should be tested against constitutional doctrine as described in prevailing judicial decisions at the time of their action"); *Skinner v. Spellman,* 480 F.2d 539 (4th Cir. 1973) (no damages against official acting in "reasonable good faith reliance on what was standard operating procedure"); *Clarke v. Cady,* 358 F. Supp. 1156, 1163 (W.D. Wisc. 1973) (prison warden "immune from damages under § 1983 when he reasonably relies upon the validity of a prison practice which has only subsequently been determined to be unconstitutional"). Thus, as the court stated in *Collins v. Schoonfield,* 363 F. Supp. 1152, 1156 (D. Md. 1973), "it would contravene basic notions of fundamental fairness if [state] officials were held to be liable monetarily for acts which

they could not reasonably have known were unlawful."[30]

The second element of the good faith defense that should be available in cases such as this would forbid personal liability whenever the doctor makes a good faith, even if unsuccessful, effort to meet the duty he or she reasonably understands is owed to the patient. Numerous courts have applied this qualified immunity principle to a wide variety of official positions. *See, e.g., Strickland v. Inlow,* 485 F.2d 186, 191 (8th Cir. 1973), *cert. granted sub nom. Wood v. Strickland,* 94 S. Ct. 1932 (No. 73-1285, Apr. 15, 1974) (school board members); *Handverger v. Harvill,* 479 F.2d 513, 516 (9th Cir.), *cert. denied,* 414 U.S. 1072 (1973) (university officials); *Jones v. Perrigan,* 459 F.2d 81, 83 (6th Cir. 1972) (FBI agent); *Harrison v. Brooks,* 446 F.2d 404, 407 (1st Cir. 1971) (town officials); *Mitchell v. Boslow,* 357 F. Supp. 199, 202-03 (D. Md. 1973) (director of state institution for "defective delinquents"). The principle is at least equally applicable to staff psychiatrists and hospital officials, whose "scope of discretion and responsibilities" is necessarily broad,

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[30] Equitable relief, of course, should always be available to insure compliance with newly developing legal standards. *See Jannetta v. Cole,* 493 F.2d 1334, 1338 (4th Cir. 1974):

> . . . while there is nothing in §1983 or the fourteenth amendment to suggest that an improper motive is requisite for a federal cause of action, conscientious state officials, when acting reasonably and in good faith, should not be expected to answer in money damages for failure to accurately predict the future course of constitutional doctrine, even though such failure may entitle a plaintiff to equitable relief.

See also Briscoe v. Kusper, 435 F.2d 1046, 1057-58 (7th Cir. 1970). Thus, the good faith defense in no way defines the right; it simply limits the remedy to equitable relief and to damages against the institution or officials who have not acted in good faith.

since they must make countless on-the-spot expert judgments each day in treating their patients. *See Doe v. McMillan, supra,* 412 U.S. at 320; *Smith v. Losee,* 485 F.2d 334, 342 (10th Cir. 1973) (en banc).

This good faith defense is particularly appropriate where, as here, fulfillment of defendant's duty is seriously hampered by thoroughly inadequate resources.[31] All that can reasonably be asked in these circumstances is that the official make a good faith effort with the limited resources available. For example, in *Schmidt v. Wingo,* 499 F.2d 70 (6th Cir. 1974), *affirming* 368 F. Supp. 727 (W.D. Ky. 1973), plaintiff sought damages from the defendant prison warden, alleging that plaintiff's decedent, a prison inmate, died as a result of inadequate medical care furnished at the prison hospital. The court in *Schmidt* recognized that it would be both illogical and unjust "to place liability upon the Warden of a penitentiary for the failure to furnish [adequate] equipment and personnel, where the budget for personnel and equipment are fixed by his superiors, the Department of Corrections and by the General Assembly of the State of Kentucky." 368 F. Supp. at 731; *see* 499 F.2d at 74.

Similarly, in the instant case the state legislature failed to appropriate sufficient funds to reduce the institution's patient-psychiatrist ratio to a level that would allow for meaningful treatment. Under such circumstances, it is far too easy for jury members—justifiably sympathetic to the plight of the plaintiff who has been confined without treatment for many years—to award damages against whatever defendant

[31] Indeed, in such cases the "good faith defense" may merge with the question whether plaintiffs can show that defendant's actions were the proximate cause of the alleged injuries.

happens to be before them.[32] Where the gravamen of the complaint is failure to provide enough treatment—as opposed to allegations of affirmative acts of malicious mistreatment [33]—proper application of this "good faith" standard should result in a verdict for defendant physicians as a matter of law whenever the evidence shows that the failure to treat resulted from inadequate resources, rather than from any personal animus.

Amicus has discussed at pp. 18-24, above, what it believes should be the basic elements of the constitutional right to treatment—the institution should provide a humane environment, adequate staff, and an individual treatment plan for each patient. Proper application of the good faith defense to these cases should immunize doctors from personal liability whenever they are using their best efforts to comply with these basic standards. It is important to emphasize that this case should not elevate to constitutional dimensions the myriad of day-to-day medical decisions that must be made in treating each patient. Indeed, it could paralyze these institutions if every doctor were

[32] *See generally Gregoire v. Biddle,* 177 F.2d 579, 581 (2d Cir. 1949):

> Again and again the public interest calls for action which may turn out to be founded on a mistake, in the face of which an official may later find himself hard put to it to satisfy a jury of his good faith. There must indeed be means of punishing public officers who have been truant to their duties; but that is quite another matter from exposing such as have been honestly mistaken to suit by anyone who has suffered from their errors.

[33] Amicus will defer to the parties' briefs on the question of whether the record here reflects a claim of bad faith mistreatment of, or simply insufficient attention to, Mr. Donaldson.

subject to a civil rights damage action in federal court each time he or she prescribed a drug, decided on a change in therapy, or acted on a request for furlough or work assignment. The Constitution does not prohibit exercise of the doctor's good faith professional judgment on any of these matters. What the Constitution should require from each doctor is a good faith effort to use the resources provided by the institution, along with the doctor's professional skill, in order to provide involuntarily committed patients the treatment implicitly promised by the state when it deprives them of their liberty.

It is an unspeakable tragedy when a mentally ill person is crowded into a facility like Chattahoochee, given little or no medical treatment, and allowed to remain there for years on end. Amicus believes strongly that such conditions violate the patient's constitutional right to treatment. The primary responsibility for a remedy, however, must lie with those who have the power to correct these conditions.[34]

The courts can find effective remedies for these problems by focusing on the institutional setting and resources available for treatment. In *Wyatt v. Aderholt, supra,* the court has used its equitable power by requiring state institutions to increase their staff-patient ratio and to make other systemic changes nec-

[34] Supporters of the right to treatment generally recognize that the understaffing and lack of physical facilities that plague our state mental institutions are not the fault of the psychiatrists or others who work there. "Our society should be grateful to, rather than adversely critical of, the personnel who continue to work in these institutions under the present trying conditions." Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499, 500 (1960); *accord, e.g.,* Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623, 628 (1971).

essary to provide adequate care. *See id.,* slip op. at 724. The American Psychiatric Association participated in the *Wyatt* case, supporting the right to treatment and urging the court to order a variety of needed institutional reforms. *See* Motion of American Psychiatric Association for Leave to Participate as Amicus Curiae, *Wyatt v. Aderholt,* No. 72-2634 (5th Cir., filed Dec. 4, 1972). The other right-to-treatment cases relied upon by the court below similarly focus on institutional reforms and injunctive relief. *See Welsch v. Likins, supra; Stachulak v. Coughlin,* 364 F. Supp. 686 (N.D. Ill. 1973). *See also Rouse v. Cameron, supra,* 373 F.2d at 458-59 (institutions must release patient receiving inadequate treatment). When a state institution fails to meet these minimum standards identified by the courts, patients should have a cause of action *against the responsible state agency.*[35] *See Whitree v. State,* 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968) ($300,000 award against state for improper custodial confinement of mental patient). Indeed, such actions may be a most effective method to loosen the legislatures' pursestrings, so that sufficient resources do become available. *See* 82 HARV. L. REV. 1771, 1776-77 (1969).

Instead of such institutional remedies, the Fifth Circuit has held in this case that the doctor who works on the staff of an overcrowded hospital can be personally liable for damages to patients who receive inadequate treatment. This decision has frightening implications for the very patients whose right to treatment the court was seeking to protect. Unless this

[35] The doctor should be personally liable, of course, if he or she fails to make a good faith effort to meet such clearly identified minimum standards, or if the doctor commits any acts of malpractice. *See generally* Morse, *Tort Liability of the Psychiatrist,* 18 SYR. L. REV. 691 (1967).

Court clearly emphasizes the availability of a good faith defense in cases such as this, it would be foolish for qualified doctors to continue working at Chattahoochee or the many other institutions that are similarly understaffed. Rather than stay in a system where their best efforts could not eliminate constant exposure to large damage awards, doctors will seek positions at the better-staffed institutions, or possibly even depart from institutional employment. Rather than increasing the quality and quantity of treatment available at Chattahoochee, the decision below will lead to just the opposite result, substantially undermining the very right to treatment it seeks to establish.

Amicus is also extremely concerned that the decision below might force institutions to release prematurely thousands of mental patients who are very much in need of care and treatment. There no doubt are many patients now in state institutions for whom release would be perfectly appropriate. Nevertheless, without further clarification by this Court of the standards for enforcement of the right to treatment, the threat of damage actions such as this one may well lead to far more widespread deinstitutionalization than is medically indicated.

Mr. Donaldson claims that, even if the resources at Chattahoochee *were* insufficient, Dr. O'Connor should be liable in damages for failing to release Mr. Donaldson once the doctor knew that adequate treatment was not being provided. But it is far too easy and misleading to characterize a doctor's decision in each case as simply whether to treat or release a patient. In the vast majority of the nation's mental institutions, doctors are providing *some* beneficial treatment to all their patients, even though the amount of treatment may be much less than the optimum in many cases. The

Court must be careful that its formulation of the right to treatment, and particularly the remedial standards for that right, do not prompt a massive reduction of the number of patients that the state will assist. A rule that forces psychiatrists prematurely to declare ready for release into society a large percentage of their mentally ill patients—so that the remaining few will receive better treatment—would be less equitable than the present mental health care system. Moreover, it might encourage the release of some patients who are extremely difficult to treat effectively, but who may be dangerous to society. *See* American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458, 1459-60 (1967) (emphasis added):

> On the basis of long experience, psychiatrists estimate that about 90 percent of all mental hospital patients are harmless and in no way threaten the community in which they reside. However, the other 10 percent comprise roughly 60,000 patients; protecting the community from irresponsible acts they might commit is a priority social concern. *To release them prematurely is never justified regardless of the adequacy of treatment they may be receiving. The constructive way of approaching this problem lies in obtaining the staff and facilities for providing adequate treatment, not in premature release.*

Many patients now confined could be treated adequately in alternative outreach, or community, facilities. Where such facilities are not available, however, the choice that a doctor faces is between providing some treatment or no treatment at all. Amicus does not suggest that large state hospital institutions are the best way to treat many of the patients now confined in such

institutions. Rather, Amicus does wish to emphasize that without the availability of alternative facilities, such patients would simply be abandoned.

Doctors trying in good faith to provide the best treatment possible with the available resources should not have to choose between risking personal liability for damages, or violating their professional standards by refusing to treat people in need of medical help.

The Court of Appeals indicated in its opinion that the "core of the charge" against Dr. O'Connor was that he confined Mr. Donaldson "knowing that the patient was not receiving adequate treatment and knowing that absent such treatment the period of his hospitalization would be prolonged." 493 F.2d at 513. The tragic truth is that the inadequate resources in our state mental hospitals today require many of our country's best psychiatrists in painful candor to confess their guilt to this same charge. The question this Court should address here is whether our judicial system can help correct the institutional inadequacies that are depriving thousands of mental patients of their fundamental rights, or whether instead the judicial response will be to punish and drive away the people who are doing the most to deal with these problems.

CONCLUSION

For the foregoing reasons, Amicus respectfully urges this Court to affirm the holding of the court below that involuntarily committed mental patients have a constitutional right to treatment, while clarifying the standards which lower courts should apply to damage actions for violation of that right.

Respectfully submitted,

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